Resources

Chapter 1

- Useful Web Sites and References for Healthy People 2010
- Oral Health Terminology
- Related Objectives from Other Focus Areas
- 1995 Progress Report for Oral Health (www.healthypeople.gov/Data/PROGRVW/PDFs/PRGORAL.PDF)
- December 1999 Progress Review, Oral Health (odphp.osophs.dhhs.gov/pubs/HP2000/pdf/prog_rvw/proral.pdf)

Useful Web Sites and References for Healthy People 2010

Most materials related to Healthy People Initiatives can be accessed through the Office of Disease Prevention and Health Promotion (ODPHP) at 1-800-367-4725 and found online at **www.health.gov/healthypeople/**. *Adobe Acrobat Reader 4.0 or above is usually necessary to view and print most of the materials. If you don't have this software, it can be downloaded from the Adobe Web site at: **www.adobe.com/products/acrobat/readstep.html**. There is an extensive site map and numerous links. Some of the resources available include:

- *HP Toolkit 2010. A Field Guide to Health Planning*. The HP 2010 Oral Health Toolkit uses many materials from this general toolkit.
- A *State Healthy People 2010 Tool Library* includes numerous samples under the Toolkit categories from state plans and meetings. Examples include surveys, interview guides, reports, slides, technical assistance documents, marketing materials, etc.
- Links to state Healthy People or state health plan Web sites
- A list of state and territorial Healthy People contacts.
- A slide show and fact sheets that provide an overview of HP 2010.
- *Healthy People in Healthy Communities*. *A Community Planning Guide Using Healthy People 2010* is a guide for building community coalitions, creating a vision, measuring results, and creating partnerships dedicated to improving the health of a community. It includes "Strategies for Success" to help in starting community activities.

Partnerships for a Healthy Workforce, funded by the Robert Wood Johnson Foundation, is a group that seeks strengthened corporate involvement in Healthy People 2010. It provides tools that businesses can use to create a healthier workplace; offers a forum for business leaders, national organizations, and state and federal agencies to share best practices; and recognizes those companies that have shown leadership in its commitment to creating a healthy workplace. Information about this group can also be accessed via **www.prevent.org**.

Healthy Campus 2010: Making it Happen, by the American College Health Association, is a workbook to help campus health professionals develop health priorities for American campuses. The 110-page document includes 3 worksheets that help users assess which national health objectives are relevant, achievable and a priority for them. It uses data from the National College Health Assessment and CDC's National College Health Risk Behavior Survey (NCHRBS). See the ACHA Web site at **www.acha.org**.

Community-Campus Partnerships for Health is a non-profit organization that fosters partnerships between communities and educational institutions that improve health professions education, civic responsibility and the overall health of communities. Look for a new resource, *Advancing the Healthy People 2010 Objectives Through Community-Based Education: A Curriculum Planning Guide,* for faculty in health professions schools and their community partners for service-learning opportunities. Information included in the guide will be relevant for courses and service-learning programs for dental and dental hygiene students, as well as other health

professions students. See information about their program at **http://futurehealth.ucsf.edu/ccph.html**.

USDHHS. *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: USDHHS, NIDCR, NIH. 2000. (**www.surgeongeneral.gov**) This is a comprehensive elaboration of the meaning of oral health and why it is essential to general health and well-being. It also covers how oral health is promoted, prevented, and maintained. The last section covers future needs and opportunities to enhance oral health.

USDHHS. *A National Call To Action To Promote Oral Health*. Rockville, MD: USDHHS, NIDCR, NIH. 2003. (**www.nidcr.nih.gov/sgr/nationalcalltoaction.htm**. The Call to Action is a follow up to *Oral Health in America: A Report of the Surgeon General* (**www.surgeongeneral.gov**) and is addressed to professional organizations and individuals concerned with oral health. The Call To Action is the product of a partnership of public and private organizations who have specified a vision, goals, and a series of actions to achieve the goals in order to accelerate the movement to enhance the oral and general health and well-being of all Americans.

Oral Health Terminology

Candidiasis (oral): Yeast or fungal infection that occurs in the oral cavity or pharynx or both.

Cleft lip or palate: A congenital opening or fissure occurring in the lip or palate.

Congenital anomaly: An unusual condition existing at, and usually before, birth.

Craniofacial: Pertaining to the head and face.

Dental caries (dental decay or cavities): An infectious disease that results in de-mineralization and ultimately cavitation of the tooth surface if not controlled or remineralized. Dental decay may be either treated (filled) or untreated (unfilled).

Caries experience: The sum of filled and unfilled cavities, along with any missing teeth resulting from decay.

Early childhood caries (ECC): Dental decay of the primary teeth of infants and young children (aged 1 to 5 years) often characterized by rapid destruction.

Root caries: Dental decay that occurs on the root portion of a tooth. (In younger persons, root surfaces are usually covered by gum [gingival] tissue.)

Dentate: A condition characterized by having one or more natural teeth.

Edentulism/edentulous: A condition characterized by not having any natural teeth.

Endocarditis: Inflammation of the lining of the heart.

Fluoride: A compound of the element fluorine. Fluorine, the 13th most abundant element in nature, is used in a variety of ways to reduce dental decay.

Gingivitis: An inflammatory condition of the gum tissue, which can appear reddened and swollen and frequently bleeds easily.

Oral cavity: Mouth.

Oral health literacy: Based on the definition of health literacy, the degree to which individuals have the capacity to obtain, process, and understand basic oral and craniofacial health information and services needed to make appropriate health decisions.

Periodontal disease: A cluster of diseases caused by bacterial infections and resulting in inflammatory responses and chronic destruction of the soft tissues and bone that support the teeth. Periodontal disease is a broad term encompassing several diseases of the gums and tissues supporting the teeth.

Pharynx: Throat.

Sealants: Plastic coatings applied to the surfaces of teeth with developmental pits and grooves (primarily chewing surfaces) to protect the tooth surfaces from collecting food, debris, and bacteria that promote the development of dental decay.

Soft tissue lesion: An abnormality of the soft tissues of the oral cavity or pharynx.

Squamous cell carcinoma: A type of cancer that occurs in tissues that line major organs.

Xerostomia: A condition in which the mouth is dry because of a lack of saliva.

Related Objectives from Other Focus Areas

1. Access to Quality Health Services
- 1-1. Persons with health insurance
- 1-2. Health insurance coverage for clinical preventive services
- 1-3. Counseling about health behaviors
- 1-4. Source of ongoing care
- 1-7. Core competencies in health provider training
- **1-8. Racial and ethnic representation in health professions**
- 1-15. Long-term care services

2. Arthritis, Osteopororsis, and Chronic Back Conditions
- 2-2. Activity limitations due to arthritis
- 2-3. Personal care limitations
- 2-7. Seeing a health care provider
- 2-8. Arthritis education

3. Cancer
- 3-1. Overall cancer deaths
- **3-6. Oropharyngeal cancer deaths**
- 3-9. Sun exposure and skin cancer
- 3-10. Provider counseling about cancer prevention
- 3-14. Statewide cancer registries
- 3-15. Cancer survival

5. Diabetes
- 5-1. Diabetes education
- 5-2. New cases of diabetes
- 5-3. Overall cases of diagnosed diabetes
- 5-4. Diagnosis of diabetes
- **5-15. Annual dental examinations**

6. Disability and Secondary Conditions
- 6-13. Surveillance and health promotion programs

7. Educational and Community-Based Programs
- 7-1. High school completion
- 7-2. School health education
- 7-3. Health-risk behavior information for college and university students
- 7-4. School nurse-to-student ratio
- 7-5. Worksite health promotion programs
- 7-6. Participation in employer-sponsored health promotion activities
- 7-7. Patient and family education
- 7-11. Culturally appropriate and linguistically competent community health promotion programs
- 7-12. Older adult participation in community health promotion activities

8. Environmental Health
- 8-5. Safe drinking water

11. Health Communication
- 11-1. Households with Internet access
- 11-2. Health literacy
- 11-3. Research and evaluation of communication programs
- 11-4. Quality of Internet health information sources
- 11-6. Satisfaction with health care providers' communication skills

12. Heart Disease and Stroke

12-1. Coronary heart disease (CHD) deaths

14. Immunization and Infectious Diseases

14-3. Hepatitis B in adults and high-risk groups
14-9. Hepatitis C
14-10. Identification of persons with chronic hepatitis C
14-28. Hepatitis B vaccination among high-risk groups

15. Injury and Violence Prevention

15-1. Nonfatal head injuries
15-17. Nonfatal motor vehicle injuries
15-19. Safety belts
15-20. Child restraints
15-21. Motorcycle helmet use
15-23. Bicycle helmet use
15-24. Bicycle helmet laws
15-31. Injury protection in school sports

16. Maternal, Infant, and Child Health

16-6. Prenatal care
16-8. Very low birth weight infants born at level III hospitals
16-10. Low birth weight and very low birth weight
16-11. Preterm births
16-16. Optimum folic acid levels
16-19. Breastfeeding
16-23. Service systems for children with special health care needs

17. Medical Product Safety

17-3. Provider review of medications taken by patients
17-4. Receipt of useful information about prescriptions from pharmacies
17-5. Receipt of oral counseling about medications from prescribers and dispensers

18. Mental Health and Mental Disorders

18-5. Eating disorder relapses

19. Nutrition and Overweight

19-1. Healthy weight in adults
19-2. Obesity in adults
19-3. Overweight or obesity in children and adolescents
19-5. Fruit intake
19-6. Vegetable intake
19-11. Calcium intake
19-15. Meals and snacks at school
19-16. Worksite promotion of nutrition education and weight management

20. Occupational Safety and Health

20-2. Work-related injuries
20-3. Overexertion or repetitive motion
20-10. Needlestick injuries

22. Physical Activity and Fitness

22-4. Muscular strength and endurance
22-5. Flexibility

23. Public Health Infrastructure

- 23-1. Public health employee access to the Internet
- 23-2. Public access to information and surveillance data
- 23-3. Use of geocoding in health data systems
- 23-4. Data for all population groups
- 23-6. National tracking of Healthy People 2010 objectives
- 23-7. Timely release of data on objectives
- 23-8. Competencies for public health workers
- 23-9. Training in essential public health services
- 23-10. Continuing education and training by public health agencies
- 23-11. Performance standards for essential public health services
- 23-12. Health improvement plans
- 23.13. Access to public health laboratory services
- 23-14. Access to epidemiology services
- 23-16. Data on public health expenditures
- 23-17. Population-based prevention research

25. Sexually Transmitted Diseases

- 25-5. Human papillomavirus infection

26. Substance Abuse

- 26-12. Average annual alcohol consumption

27. Tobacco Use

- 27-1. Adult tobacco use
- 27-2. Adolescent tobacco use
- 27-3. Initiation of tobacco use
- 27-4. Age at first tobacco use
- 27-5. Smoking cessation by adults
- 27-7. Smoking cessation by adolescents
- 27-8. Insurance coverage of cessation treatment
- 27-11. Smoke-free and tobacco-free schools
- 27-12. Worksite smoking policies
- 27-14. Enforcement of illegal tobacco sales to minors laws
- 27-15. Retail license suspension for sales to minors
- 27-18. Tobacco control programs
- 27-19. Preemptive tobacco control laws
- 27-20. Tobacco product regulation
- 27-21. Tobacco tax

From *USDHHS. Healthy People 2010. Vol II. Chapter 21. Oral Health. 2nd ed. Washington DC: US Govt. Printing Office. 2000.*

- **1995 Progress Report for Oral Health**
  www.healthypeople.gov/Data/PROGRVW/PDFs/PRGORAL.PDF
- **December 1999 Progress Review, Oral Health**
  odphp.osophs.dhhs.gov/pubs/HP2000/pdf/prog_rvw/proral.pdf

PROGRESS REPORT FOR: Oral Health

ON JULY 28, 1995, the U.S. Public Health Service (PHS) conducted a review of progress on HEALTHY PEOPLE 2000 objectives for Oral Health. The Director of the National Institute of Dental Research (NIDR), National Institutes of Health (NIH) and the Director of the Division of Oral Health, National Center for Preventive Services of the Centers for Disease Control and Prevention (CDC) reviewed strategies and barriers toward achievement of the year 2000 targets. They were joined for the review by invited guests from both the public and private sectors.

Dr. Slavkin, the new NIDR director, began the review by commenting that comprehensive care should include oral health. He suggested that new coalitions be built to align education, social services, and health services with oral health care. Dr. Marianos of CDC addressed initiatives to fluoridate community water supplies, prevent early childhood caries, and ensure the safety of both patients and dental workers through adherence to recommended infection control practices in the delivery system. Dr. Gift of NIH reviewed the state of oral health in the Nation and focused on the socioeconomic risk factors that pose challenges for achieving the year 2000 targets.

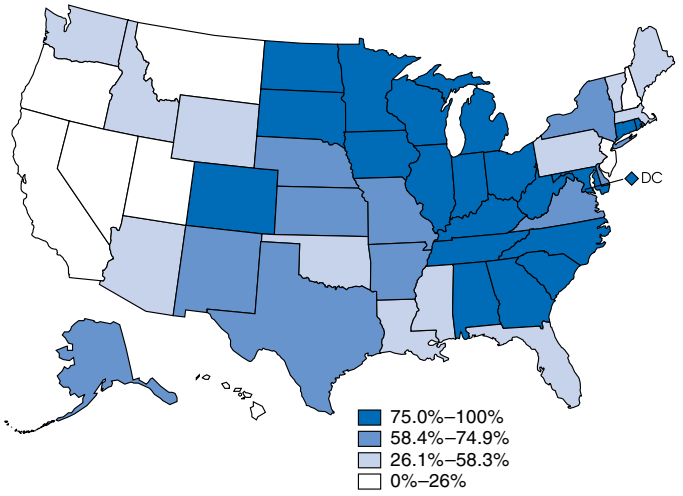
Objective 13.1 seeks to reduce dental caries. Between the 1986–87 baseline and the 1988–91 update, there has been modest change in the prevalence rates (54–52 percent) of dental caries in children. Among adolescents aged 15, dental caries has decreased over this same time period from 78 percent to 65 percent.

Objective 13.2 seeks to reduce untreated dental caries. Between the 1986–87 baseline and the 1988–91 update, there has been an apparent increase from 28 percent to 31 percent of children aged 6–8 with untreated dental caries. Special population groups—children whose parents have less than a high school education, American Indian/Alaska Native and Hispanic children—had higher rates of untreated dental caries, and that percentage increased over the past 3 years since the baseline. The percentage of adolescents aged 15 with untreated dental decay has remained at 24 percent.

Possibly the most effective strategy known to prevent dental caries is fluoridation. In this 50th year of water fluoridation, 62 percent of the people served by community water systems have optimally fluoridated water. Although new water systems have initiated fluoridation, the proportion of people receiving optimally fluoridated water remains virtually unchanged from the 1989 baseline of 61 percent. Low levels of fluoridation are found in the western States, New Jersey, and New Hampshire.

Another strategy to prevent dental caries, particularly on permanent molars, is dental sealants. Among children aged 8, the proportion having one or more dental sealants increased from 11 percent to 21 percent between 1986–87 and 1988–91. Among adolescents aged 14, the use of sealants increased from 8 to 28 percent over the same period. To reach the year 2000 target of 50 percent of children and adolescents having dental sealants requires continued efforts. One participant commented that oral health services, particularly fluorides and sealants, need to be considered as core population-based prevention services that address infectious and communicable diseases—"oral health immunizations."

Increase to 75 percent the proportion of people on public water systems served by fluoridation



Source: CDC/DOH Fluoridation Census Update, 1993

Since the publication of *Healthy People 2000*, increased attention has been given to the prevention of early childhood caries, also known as baby bottle tooth decay. One risk factor for this condition is bottle-feeding behavior. Baseline data from 1991 show that 55 percent of parents and caregivers of children aged 6–23 months reported using appropriate feeding practices—namely not giving a bottle at bedtime or giving the baby only water in a bottle at bedtime.

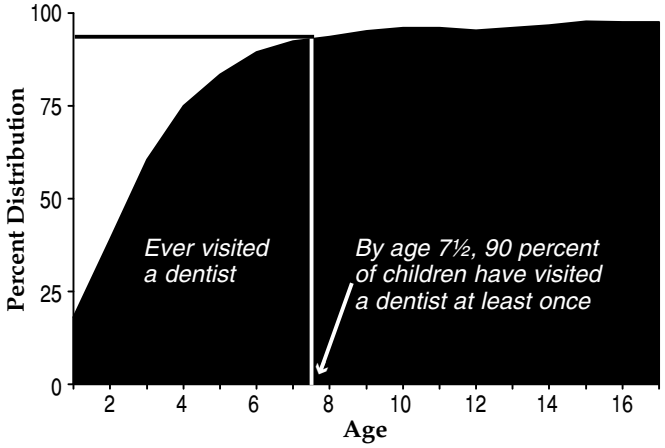
Objective 13.12 seeks to increase to at least 90 percent the proportion of children entering school who have received an oral health screening. In 1986, 66 percent of children aged 5 had visited the dentist in the past year, compared with 63 percent in 1991. This movement away from the year 2000 target is cause for concern about whether children have sufficient access to preventive dental services. When lifetime prevalence of dental visits is examined, it is not until the age of 7 that 90 percent of children have ever visited the dentist. For black children, it is not until the age of 10; for uninsured children, age 11; and for Hispanic children not until age 16 that 90 percent have ever had a dental visit.

Objective 13.3 seeks to increase the proportion of people aged 35–44 who have never lost a permanent tooth because of dental caries or periodontal disease. The 1985–86 baseline was 31 percent compared with the 1988–91 update of 32 percent. For objective

13.4, the proportion of people aged 65 and older who have lost all of their natural teeth declined from 36 percent in 1986 to 30 percent in 1993.

The discussion turned to the need to maintain focus on oral health and be diligent in encouraging and enhancing prevention at the individual, professional, and community levels. While many of the indicators of oral health demonstrate progress, lack of access to dental services, particularly for Medicaid-eligible children, is of concern. One study showed that, on average, children were enrolled in Medicaid for 3 years but had only one dental visit. A

Lifetime Prevalence of Any Use of Dental Services by Children and Adolescents Aged 2–17



Source: CDC/NCHS, National Health Interview Survey, 1989

soon-to-be-released Office of the Inspector General report on the Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program found that only one in five children were seen for dental screening services despite a program requirement that children be screened annually and followed up for dental services. Inadequate reimbursement, reluctance to treat Medicaid eligibles or young children, and cancelled appointments were cited in the study as problems. In Washington State, the ABCD Project, a partnership between the Spokane Dental Society, Spokane Health District, Medicaid program, and the University of Washington, is training some 90 dentists to see young children under age 3 and is training families on practicing good oral hygiene, keeping appointments, and behaving appropriately in the dental office.

The Assistant Secretary for Health raised a concern about the poor oral health status of American Indians. The Indian Health Service (IHS) staff responded that while there has been an increase in fluoridation in Indian communities, the biggest challenge is maintenance of systems—only 60 percent are functioning at an optimal level. While there has been progress over the past 15 years, particularly in the proportion of school-aged American Indian children who have dental sealants, there is still a gap with the total population that needs to be closed. IHS is responding with a public health focus and family-oriented services.

Participants noted major concerns about the public health infrastructure for oral health throughout the Nation. These include the lack of focus on oral health in school health education and school health services; the distribution of resources to train oral health care providers and to address oral health problems; and the lack of incentives for employment in public health settings.

The discussion turned to the risks of spit (smokeless) tobacco. A representative from Kaiser Permanente talked about a program to ensure that both medical and dental practitioners deliver the same message to their young patients. A number of professional and public education programs were mentioned. Other initiatives suggested included increasing the tax on spit tobacco and restricting accessibility to the product by minors. One participant compared the tax rates—2½ cents on a can compared with 25 cents on a pack of cigarettes—and estimated a half billion dollars in lost tax revenue a year. Higher prices as a result of taxation have been shown to be a deterrent to tobacco use by children and youth.

The discussion turned to the unmet needs of adults, including homebound and institutionalized. Root caries among older adults is becoming more common as individuals retain their teeth. More services could be provided by dental hygienists and expanded duty dental assistants if State practice acts were altered.

The progress review concluded with a summary of action items for achieving HEALTHY PEOPLE 2000 objectives. These include more effective outreach to minority and low-income people—particularly through the Medicaid program. As managed care increases in the Medicaid program, it will be important to ensure coverage of dental services, sustain enrollment, and encourage the appropriate utilization of services. PHS agencies should work with the Health Care Financing Administration to address oral health care issues in the Medicaid program. Stronger links in preschool and school health programs for oral health education and services should be created and maintained. Within PHS, the emphasis on oral health should be sustained by strengthening the professional base, by increasing training opportunities in public health dentistry, enhancing appropriate skills among a variety of health care providers in prevention of oral diseases, and providing policy guidelines, technical assistance, and resources for States and communities to pursue population-based preventive services. Prevention programs and tax policies on spit tobacco should be examined. Communication among States, communities, and the private sector on successful models of preventive activities should be enhanced. PHS should pursue national surveillance initiatives to ensure adequate information about the oral health status of Americans and support State surveillance activities. Linkages with the private sector must be sustained to ensure that the oral health status of Americans continues to improve.

Public Health Service Agencies

Agency for Health Care Policy and Research
Agency for Toxic Substances and Disease Registry
Centers for Disease Control and Prevention
Food and Drug Administration
Health Resources and Services Administration
Indian Health Service
National Institutes of Health
Substance Abuse and Mental Health Services Administration
Office of the Surgeon General

HEALTHY PEOPLE 2000 Coordinator

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PROGRESS REVIEW

Oral Health

DEPARTMENT OF HEALTH & HUMAN SERVICES ■ PUBLIC HEALTH SERVICE ■ December 15, 1999

In the concluding session of the decade-long series of Healthy People 2000 progress reviews, the Assistant Secretary for Health and Surgeon General chaired the third review of progress in achieving objectives for Oral Health. The review was organized by the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Health Resources and Services Administration (HRSA), the co-lead agencies for this Healthy People priority area. The proceedings were telecast by satellite to viewers at remote sites, who were able to submit questions by telephone and fax. Of the 17 objectives in this priority area, one (oral cancer deaths) met its target and nine are moving in the right direction. One (gingivitis) is moving away from the target and two others showed mixed results or no change. Data are not available to assess progress for four objectives. Discussion focused on the following objectives in priority area 13 of Healthy People 2000:

13.1 The proportion of children aged 6-8 years who had experienced tooth decay (caries) in primary or secondary teeth decreased from 54% in 1986-87 to 52% in 1988-94 (2000 target, 35%). For black children aged 6-8, the decrease was from 56% to 50% (target, 40%). Among 15 year-old adolescents, the proportion who had ever had caries decreased from 78% in 1986-87 to 61% in 1988-94, nearly meeting the target of 60%.

13.2 Untreated dental caries, ages 6-8—see chart. Among adolescents 15 years of age, data from 1988-94 show that the prevalence of untreated dental caries was 20% in 1988-94 (target, 15%). Of those with parents with less than a high school education, 29% had untreated caries (target, 25%), as did 29% of Blacks (target, 20%) and 36% of Mexican Americans (target, 25%). Sixty-one percent of 15 year-old American Indians/Alaska Natives had untreated caries in 1991, a decrease from 84% in 1983-84 (target, 40%).

13.3 Data from 1988-94 show that 31% of people aged 35-44 years had experienced no loss of teeth, a proportion unchanged from the mid-1980's (target, 45%).

13.4 The proportion of people aged 65 and over who had lost all their teeth decreased from 36% in 1986 to 30% in 1997. (target, 20%). In 1986, complete tooth loss had been experienced by 46% of people whose annual family income was less than $15,000; this decreased to 44% in 1997 (target, 25%).

13.6 In 1985-86, 25% of people aged 35-44 had periodontal disease which decreased to 22% in 1994 (target, 15%).

DEVELOPMENTS

- A Surgeon General's report on oral health is scheduled for release in 2000. Disparities in oral health status is a central focus, as is the fact that oral health is an integral component of overall health.
- The Oral Health Initiative of HRSA and the Health Care Financing Administration expands services and bolsters oral health infrastructure at the State and community level. It seeks to increase access to dental care for children eligible for assistance from Medicaid and the Children's Health Insurance Program.
- Beginning in 2001, HRSA, CDC and NIH plan to fund several Centers for Research to Reduce Oral Health Disparities. The centers will focus on children and their care-givers and span the spectrum from basic to community-based research and health promotion.
- CDC and the Association of State Dental Directors are jointly developing a State-based national oral health surveillance system.
- Minority enrollments in dental schools need to increase three-fold to appropriately raise, by 2025, the proportion of minorities represented among providers of dental care (a Healthy People 2010 objective).
- People with low income or a low level of educational attainment are three times as likely to have tooth decay and only half as likely to have visited a dentist as the total population.

13.7 Oral cancer mortality—see chart.

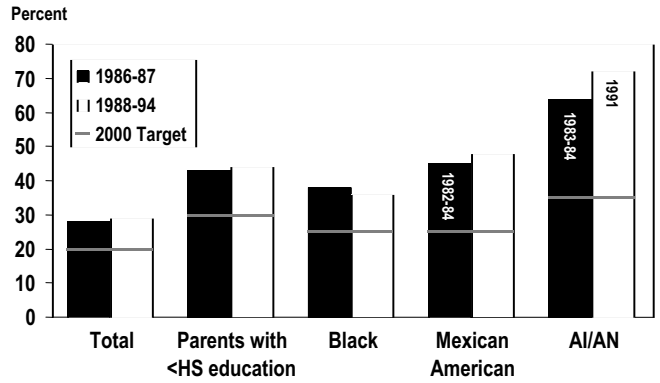
13.8 Protective dental sealants for 8-year-old children increased between 1986-87 and 1994, as follows: for all, from 11% to 23%; for Blacks, from 4% to 11%; for Mexican Americans from 9% to 7%. For 14-year-olds: for all, from 8% to 24%; for Blacks from 3% to 5%, and for Mexican Americans, from 6% to 7% (target, 50% for all groups).

13.9 The proportion of people served by community water systems whose drinking water was adequately fluoridated increased only slightly, from 61% to 62%, between 1985 and 1992 (target, 75%).

13.14 Between 1986 and 1997, the proportion of people aged 35 and over who had visited a dentist in the previous year increased from 54% to 63% (target, 70%). Over the same time period, the proportion of edentulous people aged 35 and over regularly visiting a dentist increased from 11% to 20% (target, 50%) and the proportion of people aged 65 and over doing so increased from 42% to 55% (target, 60%). Between 1991 and 1997, the proportion of other select population groups in the age group 35 and over who had regular dental visits increased as follows: for Blacks, from 43% to 53%; for Mexican Americans, from 38% to 47%; and for Puerto Ricans, from 51% to 54% (target, 60% for each).

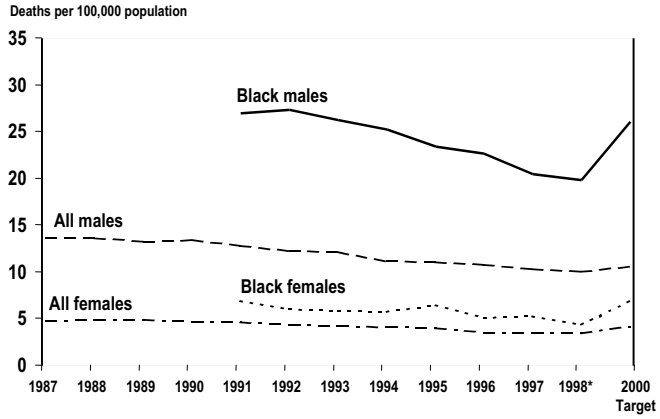
13.17 Use of smokeless tobacco by males aged 12-17 years decreased from 6.6% of this population in 1988 to 3.7% in 1997, surpassing the target of 4%. Use by males aged 18-24 declined from 8.9% in 1988 to 6.9% in 1994.

13.2 - Children aged 6 to 8 years with untreated tooth decay in permanent or primary teeth



Source: National Survey of Dental Caries in U.S. School Children, NIH, NIDR; National Health and Nutrition Examination Survey, CDC, NCHS; NC Oral Health School Study, UNC School of Public Health; Survey of Oral Health, IHS; Oral Health Status and Treatment Needs Survey of American Indians/Alaska Natives, IHS.

13.7 - Deaths due to cancer of the oral cavity and pharynx in people aged 45 to 74 years



*Data are preliminary.
Source: National Vital Statistics System, CDC, NCHS.

DEVELOPMENTS (Cont'd.)

- In California, one of the western States where fluoridation levels have historically been lowest, a law now requires communities with a population greater than 10,000 to fluoridate their drinking water. Los Angeles began fluoridating its water supply in August 1998 and Sacramento has recently begun to do so.
- Only nine percent of U.S. adults in 1998 reported that they had been screened for oral cancer in the past year. On average, people who develop oral cancer have made over ten visits to a physician in the year preceding diagnosis of the disease.
- Twenty-five percent of all children 5-17 years of age account for 80 percent of all dental caries.
- Fluoridation is an effective means to prevent tooth decay and has greatest benefits for those most in need of dental care. Twenty States and the District of Columbia have met the Healthy People 2000 target for fluoridation.
- Periodontal disease can affect diabetes control and be associated with low birth weight and premature babies, cardiovascular disease, stroke and pulmonary disease.

FOLLOW-UP

- Concentrate and coordinate resources needed to close the gap in access to preventive and restorative dental health services, especially for racial and ethnic minorities and those with low levels of education.
- Step up efforts to recruit racial/ethnic minorities into the public and private sectors of the dental profession and allied health professions.
- Continue to build and expand public/private partnerships to improve oral health, incorporating community multi-cultural coalitions.
- Extend the reach of activities to inform the public that most oral diseases are preventable and that dental sealants and fluorides (in water, toothpaste, mouthrinses and professional applications) have proven preventive health benefits. Ensure that these public messages are culturally and ethnically sensitive.
- Stem the increase in dental caries in younger children, with a special focus on minority and low-income segments of the population.

PARTICIPANTS

- Administration on Aging
- Academy of General Dentistry
- American Academy of Pediatric Dentistry
- American Dental Association
- American Dental Hygienists' Association
- American Association of Dental Schools
- American Association of Public Health Dentistry
- American and International Associations for Dental Research
- American Public Health Association
- Association of Community Dental Programs
- Association of State and Territorial Dental Directors
- Boston Department of Health
- Center for Policy Alternatives
- Centers for Disease Control and Prevention
- Children's Dental Health Project
- Cincinnati Health Department
- Connecticut Department of Public Health
- District of Columbia Commission of Public Health
- Federal Bureau of Prisons
- Food and Drug Administration
- Health Care Financing Administration
- Health Resources and Services Administration
- Hispanic Dental Association
- Indian Health Service
- Los Angeles County Department of Health
- Maryland Department of Health and Mental Hygiene
- Minority Oral Health Research Center
- National Dental Association
- National Institutes of Health
- Nebraska Department of Health and Human Services
- New York University
- Office of Disease Prevention and Health Promotion
- Office of Public Health and Science
- Ohio Department of Health
- Oral Health America
- Pan American Health Organization
- Special Olympics, Inc.
- University of California/ San Francisco
- University of Maryland
- Voices of Detroit Initiative

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